Blood-Stream Infection (CDC)

From: Weber, Joan M.,Shriners [JWEBER@PARTNERS.ORG]
Sent: Wednesday, November 11, 2009 1:43 PM
To: Blood-Stream Infection (CDC)
Subject: Comments on the Draft Guidelines for Prevention of Intravascular Catheter Related Infections

Thank you for the opportunity to comment on the guidelines. This is very comprehensive and evidence-based guideline for prevention of intravascular catheter associated infections.

1. Regarding catheter site dressings starting on line 457, can you include a comment on how to care for sites which must be placed through or near an open wound. In particular I am referring to patients with large open burn wounds when the physicians may not have an option of inserting the catheter through unburned skin. I realize this has not been adequately studied and may remain an unresolved issue but this a fact when caring for these patients. In our experience we use a non-occlusive betadine dressing which is changed every 4 hours and seems to work well and betadine does cover both bacterial and fungal organisms. This could also be mentioned on line 668 discussing antibiotic/antiseptic ointments.

2. On line 624, can you please mention that at the present time the only antimicrobial coated catheters for pediatric populations that are internally and externally coated are the minocycline/rifampin catheters? To my knowlege the chlorhexidine/silver sulfadiazine catheters are only available in adult sizes and the one for pediatrics are only externally coated.

3. Beginning on line 841 could you include a comment on routine changes of CVCs in the burn population as an unresolved issue. This population, particularly patients with >20% open wounds may require CVCs for very extended periods of time and have a much greater risk of hematogenous seeding of the catheter from the burn wounds than any other patient population. They are also at increased risk of seeding of the catheter from the insertion site if the line must be inserted through or near the open wound. I am not aware of any multicenter trials in the past 20 years that has examined this issue in the burn population and there currently exists significant difference of opinion among burn professionals on how often CVCs should be routinely changed in this population. The comment that PICC lines should be used for central vonous access instead of CVCs when IV therapy is expected to last more than 6 days is also of concern in the burn population for these same reasons (line 292).

4. In the beginning of the guideline an explanation of the use of CABSI vs. CRBSI was given (line 140-144) but the terms seem to be used interchangably in the remainder of the guideline. This is very confusing and one or the other should be used consistently.

Thank you again for the opportunity to comment.

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